DOCUMENT RESUME

ED 298 594 CS 506 376

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TITLE The Dialogue of Desperation: Toward a Communication Perspective on Suicide.
PUB DATE Nov 88
NOTE 19p.; Paper presented at the Annual Meeting of the Speech Communication Association (74th, New Orleans, LA, November 3-6, 1988).
PUB TYPE Speeches/Conference Papers (150) -- Information Analyses (070)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Communication (Thought Transfer); *Communication Research; Self Destructive Behavior; *Suicide
IDENTIFIERS Communication Behavior; *Suicide Intervention; Suicide Prevention

ABSTRACT

Despite convincing evidence that suicide is, in fact, an act of communication, communication researchers have not made significant contributions to this body of literature. Various disciplines have noted the relationship of self-destructive behavior to communication. Suicidal behavior has been labeled an act of communication that can be a final message, or if the act is not fatal, one which elicits a response. It also has been suggested that perception of direct and indirect communication cues can play a significant role in suicide prevention. It is important to hear the dialogue of desperation. Until the suicidal person refuses to seek communicative interaction from others, there is hope for successful intervention. Hence a communication perspective on suicide would be very useful for several areas of future research. These areas include: (1) a model of communication which focuses on the unique exigencies of suicidal messages; (2) the role of nonverbal communication in suicide; (3) perceptual processes of suicidals; (4) suicide as a crucial self-disclosure; (5) listening behavior of those who are told of suicidal thoughts; and (6) rhetorical implications of suicide ideation. (Thirty-three references are appended.) (MS)

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The Dialogue of Desperation:

Toward a Communication Perspective on Suicide

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Paper presented at the annual meeting of the Speech Communication Association, New Orleans, November, 1988.

CS506376

Abstract

This essay examines some of the various findings contained in the current literature on suicide. Fields such as medicine, psychology, and sociology testify to the important relationship of self-destructive behavior to communication. However, a distinct communication perspective on suicide is lacking in this body of literature. Such a perspective consequently is proposed for future research.

The Dialogue of Desperation:
Toward a Communication Perspective on Suicide

> The masses of men lead lives of quiet desperation--
> Henry David Thoreau.

Suicide is an act of human desperation that often defies explanation. Various professionals and academicians continue to seek answers--particularly in the fields of medicine, psychology, and sociology. Communication researchers have not made significant contributions to this body of literature despite convincing evidence that suicide is, in fact, an act of communication.

The important relationship of self-destructive behavior to communication has been noted by psychiatrists and suicidologists. Graff and Mallin (1967) suggested that wrist slashers have a common behavior pattern stemming from early maternal deprivation and imbedded in an inability to give and receive meaningful verbal communication. Bonnar and McGee (1977) interpreted suicidal behaviors as acts of communication directed to some person important in the social life of the potential victim. They believed that suicidal behavior always bears some relation to the interface between the actor and other people. Accordingly, whether intended or not, suicidal acts convey a message. "If it (an attempt) is fatal, it is a final message; if it is not fatal, it is a part of a dialogue" (Stengel, 1969, cited in Bonnar and McGee, 1977, p.7).

Unfortunately, communication researchers have contributed little to the dialogue of suicide. An examination of the diverse literature in the field of communication reveals a definite lack of research in this area. Thompson (1984) observed that communication research in health and social services may be very limited because it is so "emotionally demanding" (p. 150). While the emotional demands of such research are high so are the potential insights to be gained. Consequently, I shall review some of the various perspectives on suicide research. Then, the implications of a communication perspective on suicide will be examined.

Current Perspectives on Suicide

Psychologists commonly divide suicidal behavior into three categories: (1) suicidal ideation, (2) attempted suicides, and (3) completed suicides. It has been estimated that 80 percent of all individuals will admit to having entertained suicidal thoughts (Meerloo, 1962). According to Victoroff (1983), "Man may be the only species that questions the value of life, and with varying degrees of volitional and knowing intent assumes the right to terminate it prematurely" (p. 215). Jacobs (1972) argued that suicidal ideation frequently serves a life-maintaining function by providing the comforting reassurance that if life becomes too unbearable one can always opt out.

Completed suicides, nonetheless, constitute a major public health problem as approximately 22,000 are recorded annually in the United States. It is the second most common

cause of death on college campuses, the leading cause of death among medical students, and the third cause of death among teenagers (Patterson et al., 1983). Despite research and public health efforts, suicide rates show a relative consistency over time (Bassuk, Gill, and Schoonover, 1982).

The aftermath of suicide is a particularly difficult period for surviving loved ones. In addition to the obvious "grief," they may experience a number of emotions, such as confusion, guilt, anger, and a certain amount of social stigmatism. For emotional as well as financial (life insurance) reasons, survivors often prefer to believe that suicides were accidental. Thus, unless there is a suicide note, many cases may be difficult to label as certain suicides. Since only about 15 percent of the completed suicide population leaves notes (Neuringer and Lettieri, 1982), a number of probable suicides are categorized as "uncertain."

Speculation as to why suicide occurs can be viewed from a sociological and psychological perspective. Modern suicidology began with sociologist Emile Durkheim's 1887 work, Le Suicide. Durkheim believed that it was useless to study single cases but that rather one had to study society (cited in Hatton and Valente, 1984). Suicide from such a sociological perspectiive could be related to problems in social integration or interpersonal communication.

The work of Sigmund Freud and psychoanalysis (in the 1920s) provided a different viewpoint of suicide. According to Freud, the suicidal person has an aggressive drive that is not outwardly expressed but is instead turned against the

person (cited in Hatton and Valente, 1984). Kisker (1964) concluded that attempted suicide may represent a surrendering to hostile impulses by turning toward oneself in an intropunitive manner. Suicide from such a psychological perspective could be related to problems in personal integration or intrapersonal communication. More recently, there has been much speculation about the genetic as well as biochemical basis of suicidal behavior.

Sex and Age Differences

There are distinct male versus female patterns when examining specific reasons for suicide. Several researchers (e.g., Breed, 1967; Maris, 1981; and Mishara, 1982) found that loss of person was especially predominant among female suicides and that loss of job was a major cause for male suicides. Breed (1972) viewed "failure" as the basic concept for both sexes: failure with family or relationships with women and failure in career goals with men. One may certainly speculate that with increased career orientation, women may demonstrate a shift in reasons for suicide.

There are also age differences in suicidal behavior. Older people tend to communicate their suicidal intentions less frequently, to use lethal weapons more often, and to be more successful in killing themselves than the young. Unlike many younger people, the aged do not often use suicidal activities as a means of manipulating others, calling attention to themselves, or crying out for help (Miller, 1979). While individuals over 45 years represent approximately 20 percent of the general population, they

account for over 60 percent of the completed suicides (Lyons, 1984). It should be noted, however, that suicides among 15 to 19 year olds have tripled in the last quarter-century. At greatest risk are adolescents who have experienced bitter custody battles, violent homes, or a recent death in the family (Martz et al., 1987, March 23).

Signs of Suicide

Regardless of sex and age differences, are there general "signs" of potential suicidal behavior? Smith (1981) acknowledged the complexity of interpreting potential suicidal behavior: "Signs usually are given by nonsuicidal patients as well, and a cut-off point for the number of responses that adequately distinguishes suicidal patients is not known" (p. 561). Additionally, there are variants of suicide which sometimes amount to a substitution for the act while exhibiting many of the same signs. Victoroff (1983) labeled these as "minisuicide" and "symbolic" suicide. Minisuicide may involve a major decomposition or reversal of one's personality. Symbolic suicide may involve destroying one's prized belongings or an unexpected resignation from a long-held or prestigious position.

While misinterpretation of actual suicidal cues may occur, there are clinical characteristics which place a person in a category of especially high risk for suicide. Hatton and Valente (1984) isolated five such characteristics:

1. Multiple high-lethality suicide attempts
2. Alcohol abuse
3. Isolation/withdrawal

4. Disorientation/disorganization

5. Hostility

Interestingly, Victoroff (1983) asserted that alcoholism was as often the underlying agent of suicide as all the other possible agents combined. Patterson et al. (1983) estimated that 15% of all alcoholics eventually commit suicide.

The most obvious sign of impending suicide would seem to be a direct communication to someone of that intention. There are fairly diverse findings regarding the percentage of those who communicate their intent to commit suicide beforehand. For example, Dorpat and Boswell (1963) claimed that 83 percent of the suicidal population convey their thoughts to others. Shneidman (1987, March) estimated that 80 percent of suicidal people give friends and family clear clues about their intention to kill themselves. Kovacs, Beck, and Weissman (1976), however, found a much lower percentage--between one-third and one-half.

Beck and Lester (1976) observed that the major difference between completed and attempted suicides centered around communication: "For the completed suicide the decision appears to be whether or not to communicate; for the attempted suicide the decision appears to be when to communicate" (p. 35). Other researchers appear to concur with this notion that communication of intent is particularly prevalent among those who are still deliberating the suicide question. In discussing suicide prevention centers, Lester (1972) concluded that these services are generally used by those who are suffering from suicidal thoughts rather than those who ultimately commit suicide.

Suicide Intervention

What then are the prospects for effective suicide intervention? Some researchers (e.g., Bassuk, Gill, and Schoonover, 1982; Ringel, 1976; and Wood and Litman, 1973) have argued that completed suicides are the result of suicidal lifestyles and not actually related to isolated crises or stress. Such suicidals experience a progressive immobilization and loss of internal and external resources. Moreover, they rarely seek help during the later stages of their suicidal careers. These observations would appear to minimize the impact of possible intervention.

There are, however, various perspectives on the methods and relative success of suicide intervention. Victoroff (1983) labeled suicide as the "most readily preventable lethal disease in all medicine..." (p. xxi). Victoroff believed that recognition and treatment of potential victims are certainly possible given the fact that more than one-third of the patients who take their own lives have seen a physician within three months of their suicide.

In assessing the problem of "wrist slashing" as a physical, preverbal method of relief from anxiety, Graff and Mallin (1967) argued that initial therapy must be through a similar preverbal manner (i.e., tactile communication). As therapy progresses, these nonverbal therapeutic messages should evolve into verbal messages. Graff and Mallin consequently concluded that the "aim of therapy is to assist the patient to mature to the point where she can utilize words rather than primitive gestures as a sign of a

relationship with an important other person" (p. 79).

Mishara (1982) examined responses to suicidal thoughts labeling them as either open (i.e., encouraging discussion and showing concern) or closed (i.e., ignoring, joking or directing elsewhere for help). Mishara concluded that with very few exceptions, an open response was at least perceived as "helpful."

Jourard (1971) believed that "meaningful others" can, in fact, provide an impetus for suicide by giving "invitations to die." Jourard observed: "I suspect we would find that for people who kill themselves, or who die before they should, we would find evidence of the wish that they die existing at some level of consciousness in the people around them" (p. 98).

Few researchers question the fact that caregivers need to be sensitive to the communicated signs of suicide. Moreover, Rudestam (1972) concluded that the "noncommunicating" suicidal does not really exist as there are indirect cues or communication that have "prophylactic" significance. The suicidal's time orientation has been viewed as a particularly illuminating cue. James (1984) believed that the caregiver could use the client's ability or inability to project into the future and make plans as a gauge of the seriousness of suicidal intent. Similarly, Greaves (1971) found that suicidal patients were significantly more present-oriented than the nonsuicidal groups, the latter using more future tense verbs.

Suicidal vs. Non-Suicidal Character

A final matter of interest contained in the literature on suicide is the notion of "survival." Specifically, what distinguishes the survival instincts of the suicidal from the non-suicidal? Breed's (1972) "five components of the basic suicide syndrome" provide a revealing profile of the suicidal character:

> He sees (perhaps exaggerates) his failure and the adverse reactions of others; he will not abandon his ambitious commitment, cannot lose rigidity, cannot avoid shame, and refuses to beg others for communicative interaction (pp. 16-17).

Conversely, McCall and Simmons' (1966) "mechanisms of legitimation" describe strategies used by the ordinary person to escape the effects of heavy blows to self-esteem:

> He uses selective perception of cues and selective interpretation of evaluations of his role performance; he rationalizes, insulates himself from threat, disavows commitment, uses scapegoating against critics, switches roles to those more rewarding to his identity, and changes social contacts to those who reward more and punish less (cited in Breed, 1972, p. 16.).

According to the preceding profiles, it appears that survival is largely a matter of positive selectivity in perception, exposure, and retention. Given the seemingly "perceptual" bases of suicide, additional communication perspectives could provide important insights into the literature of suicide. Not surprisingly, Breed (1972)

argued that suicide intervention can, in fact, work until social isolation has completely set in. Thus, the "door is not shut," according to Breed, "until the suicidal refuses to seek communicative interaction from others" (p. 17).

Toward a Communication Perspective on Suicide

There is a clear mandate for additional communication perspectives on suicide. Various disciplines have noted the relationship of self-destructive behavior to communication. Suicidal behavior has been labeled an act of communication that can be a final message, or if the act is not fatal, one which elicits a response. It also has been suggested that perception of direct and indirect communication cues can play a significant role in suicide prevention. Finally, until the suicidal refuses to seek communicative interaction from others, there is hope for successful intervention. Consequently, I would like to propose a communication perspective on suicide for several areas of future research.

While there are numerous linear, non-linear, and transactional models of communication, one which focuses on the unique exigencies of suicidal messages is needed. A pictorial representation could provide an important "therapeutic tool" for caregivers. Such a symbolic representation could further illuminate recurring messages of desperation as well as the relative use of verbal versus nonverbal channels. The receiver's crucial feedback in response to suicidal messages also may be examined.

Another potential area of investigation is the role of nonverbal communication in suicide. One could examine the nonverbal messages of both the suicidal careseeker and caregivers. As indicated in previous research, is tactile communication particularly helpful in initial therapeutic situations?

The seemingly distinct perceptual processes of suicidals would provide a fruitful area for communication scholars. It appears that there are differences in the in the information processing systems of the suicidal versus the non-suicidal. Do suicidals selectively perceive or even distort information such that it maximizes ego damage? Conversely, how would a non-suicidal perceive similar information?

The communication of one's contemplation of suicide would certainly be categorized as self-disclosure, i.e., the act of revealing personal information to special others. Communication research on suicide as a crucial self-disclosure topic is vital. Questions such as who receives this highly personal self-disclosure and why they are sought out could provide important information about the act of suicide. Additionally, communication researchers may examine the aftermath of inappropriate self-disclosure of suicide ideation.

Obviously, the listening behavior of those who are told of suicidal thoughts is critical. Previous research has observed that there are many subtle suicidal messages, such as time orientation, that demand important listening skills

of caregivers. What are the ramifications of a closed or evaluative listening style versus an open or empathic one? What are the risks involved in creating a defensive versus a supportive listening climate?

Finally, communication researchers may explore some of the rhetorical implications of suicide ideation. Is there a discernible rhetoric of suicidal desperation? Do rhetors who have previously expressed suicide ideation demonstrate a recurring form such as Breed's five components of the suicide syndrome? Thus, isolated public discourses could be examined relative to underlying themes of failure, commitment, rigidity, shame, and social isolation.

In light of previous findings, I have proposed several areas of suicide research that would benefit from a communication perspective. Granted, there are many other areas to probe. It behooves our discipline to acknowledge the role of communication in suicide and finally to hear this dialogue of desperation. In the words of Edwin Shneidman, founder of the American Association of Suicidology: "It is a sad fact that suicides are not essentially acts of hostility or revenge, as many people think, but are individuals' attempts to get others to see their pain and stop them from killing themselves" (1987, March, p. 58).

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